STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DINC	00	COMPL	ETED
		155567	A. BUII B. WIN			07/19/2	011
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	£			EDICAL PARK DRIVE		
UNIVERS	SITY PARK HEALTH	HAND REHABILITATION CENTER	1		WAYNE, IN46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was for	r the investigation of	F0	000	This Plan of Correction is the center's credible allegation of compliance.		
	Complaint Numb	per IN00092713.			creatible allegation of compliance.		
	-				Preparation and/or execution of this	s plan	
	Complaint Numb	per			of correction does not constitute admission or agreement by the pro	vider	
	•	ostantiated. Federal/state			of the truth of the facts alleged or		
					conclusions set forth in the stateme		
		ted to the allegations are			deficiencies. The plan of correction prepared and/or executed solely be		
	cited at F 226,	F 279, F 282 and F 323.			it is required by the provisions of fe		
					and state law.		
	Survey dates: Jul	ly 18, 19, 2011					
	Facility number:	000459					
	Provider number	r: 155567					
	Aim number: 10	0289700					
	111111111111111111111111111111111111111	0_03,00					
	Survey team:						
	-						
	Ann Armey, RN						
	Census bed type:						
	SNF: 2	•					
	SNF/NF:72						
	Total: 74						
	Census payor typ	be:					
	Medicare: 16						
	Medicaid: 43						
	Other: 15						
	Total: 74						
	Sample: 3						
	Sumpie. S						
	These deficienci	es reflect state finding					
		•					
	cited in accordan	nce with 410 IAC 16.2.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

V1SZ11

Facility ID:

000459

If continuation sheet

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155567 07/19/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1400 MEDICAL PARK DRIVE UNIVERSITY PARK HEALTH AND REHABILITATION CENTER FORT WAYNE, IN46825 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Quality review completed 7/21/11 Cathy Emswiller RN The facility must develop and implement F0226 written policies and procedures that prohibit SS=C mistreatment, neglect, and abuse of residents and misappropriation of resident property. It is the policy of this facility to F0226 08/17/2011 Based on interview and record review, the develop and implement written facility failed to develop a policy stating policies and procedures that prohibit all alleged violations involving mistreatment, neglect, and abuse of mistreatment, neglect, or abuse, including residents and misappropriation of injuries of unknown source and resident property. No residents were directly affected misappropriation of resident property are by the deficient practice. reported immediately to the Administrator All residents had the potential to be of the facility. This deficiency potentially affected by the deficient practice. affected all 74 residents residing in the The facility's Abuse Prevention, facility. Intervention, Investigation and Reporting Policy have been revised to show that the administrator shall Findings include: be notified immediately by employees of any suspected, The abuse policy, revised March 2011, instances, or allegations of abuse. All provided by the Administrator, was staff shall be inserviced on the change in policy terminology on reviewed on 7/19/11 at 9:15 a.m. with the 8/9/2011. Administrator. The policy indicated, QA&A Committee will monitor any among other things, that "... allegations or instances of abuse for a It is the responsibility of employees to period of 6 months or until pattern of promptly report to the facility consistent compliance achieved with a subsequent plan developed and Administrator any incident of suspected implemented as indicated to insure or alleged neglect or resident abuse from that the administror is notified other residents, staff, family, or visitors; immediately by employees. including injuries of unknown source and theft or misappropriation of resident

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL		
		155567	B. WIN			07/19/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	SITY PARK HEALTH	AND REHABILITATION CENTE	R	1	VAYNE, IN46825		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	· ·				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	
(X4) ID PREFIX TAG	responsibility to promptly investigemet. On 7/19/11 at 9:3 was interviewed. policy had been reindicated he felt in mediately" has and were equivalent.	the facility requires that poly report the facts of the distances of abuse as of abuse to the facility of that facility's protect residents and gate occurrences may be as of a.m., the Administrator He indicated the abuse recently updated. He the words "promptly" and ad the same definition		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	(XS) COMPLETION DATE
	,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/G		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		155567	B. WING			07/19/2	011
			D. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				EDICAL PARK DRIVE		
UNIVERS	SITY PARK HEALTH	AND REHABILITATION CENTER			VAYNE, IN46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	•	TAG	DEFICIENCY)		DATE
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.						
	are to be furnished resident's highest mental, and psych required under §44 would otherwise b but are not provide exercise of rights right to refuse treasures.	st describe the services that d to attain or maintain the practicable physical, losocial well-being as 83.25; and any services that e required under §483.25 and due to the resident's under §483.10, including the attment under §483.10(b)(4).	F02	279	It is the facility's policy to use t	he	08/17/2011
	record review, the develop, and review, the develop, and review falls. This deficies residents with most of 3. (Resident # Findings include The closed clinic was reviewed on indicated the rest facility from the diagnoses which limited to, demend Vascular Accident	e facility failed to ise care plans to prevent ency affected 2 of 3 ultiple falls in a sample B, and #C)	102		results of the assessment to devereview and revise the resident's comprehensive plan of care. Resident B was discharged from facility on 6/21/11, unable to address. Resident C falls carepl was reviewed on 7/29/11 by ID'ensure appropriate and progress interventions have been put in p to minimize falls. Other residents with multiple fa previous 3 months shall be review by IDT to ensure appropriate progressive interventions have be put in place to minimize falls. Licensed Nursing staff and IDT reeducated on facility's fall management program policy an procedure. DON or designee w review all falls and intervention	elop, lan T to sive blace lls in ewed to be d	00/1//2011

V1SZ11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155567	B. WIN			07/19/2011
			B. ((1))		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				EDICAL PARK DRIVE	
UNIVERS	SITY PARK HEALTH	AND REHABILITATION CENTER	?		VAYNE, IN46825	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
	6/21/11.				ensure that the most appropriate	l l
					measures have been put in place	
	The fall risk asse	essment, dated 5/16/11,			minimize the risk of falls for the resident.	
	indicated Resider	nt #B was at high risk for			QA&A will monitor residents w	zith
	falls.	_			multiple falls monthly to ensure	l l
					effectiveness of the staff utilizat	
	The fall risk care	plan, dated 5/16/11,			of the falls management program	m for
		nt #B had fall risk			a period of 6 months or until pa	
		g; CVA, dementia,			of consistent compliance achiev	l l
					with a subsequent plan develop	ed
		story of falls. The fall			and implemented as indicated.	
	•	rentions included:				
	Provide adequa					
	Monitor side ef	fects of meds				
	(medications)					
	Keep call light	within reach				
	Encourage use	of call light				
	Keep floors free	e of spills and clutter				
	•	steady gait and balance				
	Labs as ordered					
	Assess toileting					
	Provide verbal s					
		pelongings within reach				
	•	devices within easy reach				
	(Wheel Chair)	15 1				
	,	and) clear eye wear				
	Provide non-ski					
		al therapy evaluation)				
	and treat if indicate					
	OT eval (occup	ational therapy				
	evaluation) and t	reat if indicated				
	Pressure sensor pad in bed (and) w/c					
	(wheelchair)					
	Low bed					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155567	B. WIN			07/19/2	011
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					EDICAL PARK DRIVE		
UNIVERS	SITY PARK HEALTI	HAND REHABILITATION CENTER	₹	FORT V	VAYNE, IN46825		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	-	, dated 5/16/11 and					
	•	vely, indicated Resident					
		a PSA (Pressure Sensor					
	· ·	ed/ wheelchair at all times					
		ve Physical/Occupational					
	1.5	es per week for eight					
	weeks.						
	MDS (Minimum	Data Set) Assessment,					
	dated 5/23/11, in	· · · · · · · · · · · · · · · · · · ·					
	· ·	uired extensive assistance					
	for transfer and t						
		f Interview of Mental					
	`	the MDS assessments,					
	<i>'</i>	26/11, and 6/7/11,					
	indicated Reside						
	cognitive impair	ment.					
	Resident #B sust	ained three unwitnessed					
		5/20/11 and 6/4/11; as					
	follows:	5/20/11 and 6/ 1/11, as					
	On 5/19/11 at 5::	50 p.m A fall					
		m indicated resident #B					
		eelchair. According to the					
		eard the PSA (Pressure					
	_	ounding and found the					
		oor sitting in front of her					
	wheelchair.						
		as educated 0 (not) to					
		get objects out of reach, to					
	_	ask for assistance" The					
	_	Resident #B complained					
	_	an x-ray of the right hip					
		neuro checks were					
	,, as stacted and	nono checko were			<u>L</u>		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	155567	A. BUI	LDING	00	07/19/2	
		100007	B. WIN			01/19/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	SITY PARK HEALTH	I AND REHABILITATION CENTI	FR	1	EDICAL PARK DRIVE VAYNE, IN46825		
					77.1112, 111.10020		(2/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	initiated.	,					
	On 5/20/11 at 8:0	00 a.m., Resident #B					
	sustained a secon						
	A change of cond	lition report, dated					
	I -	d Resident #B was					
	· ·	on the bathroom floor,					
		en removed, and the					
		npted to self transfer to					
		st-fall care plan indicated					
	"encouraged use	•					
	assistance."	C					
	CNA #1, who dis	scovered the resident on					
	the floor, was int	erviewed on 7/19/11 at					
	12:00 noon, and	indicated the resident's					
	alarm was not so	unding, when she					
	discovered the re	sident on the bathroom					
	floor. She indicat	ted the resident had shut					
	off her alarm.						
	The right hip x-ra	ay report, dated 5/20/11,					
	noted an irregula	rity and bony fragment at					
	the greater trocha	anter.					
	Nursing notes, da	ate 5/21/11 at 7:50 a.m.,					
	indicated physici	an orders were obtained					
	to transfer the res	sident to the emergency					
	room for evaluati	ion of the right hip.					
	The hospital eme	ergency report, date					
	5/21/11 at 1:12 p	.m., indicated Resident					
	#B was returned	to the facility following					
	an examination a	nd a normal MRI					
	(Magnetic Reson	ance Imaging) of the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155567	B. WIN			07/19/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					EDICAL PARK DRIVE		
UNIVERS	SITY PARK HEALTH	AND REHABILITATION CENTE	R	1	VAYNE, IN46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	right hip.		İ				
	On 6/5/11 at 3:3	0 p.m., Resident #B					
	sustained a third	-					
		ation report indicated the					
	_	ing and Resident #B was					
	found on the floo	_					
	According to the						
	_	sfer from the wheelchair					
	•						
		at assistance and missed					
	-	ort indicated the "resident					
		on use of call light." The					
		nd non-skid socks,					
	previously care p	lanned, were continued.					
	•	licated the only new fall					
	•	ention attempted for the					
	cognitively impa	ired resident, following					
	the falls, was re-	education and					
	encouragement to	o use the call light. There					
	was no document	tation the use of the PSA					
	alarm was review	ved or that the need for					
	additional superv	vision was considered or					
	planned.						
	_						
	On 7/19/11 at 12	:10 p.m., the					
		as interviewed regarding					
	Resident #B's fal						
		dementia resident was					
		te intervention. He					
		tangible" interventions					
		-					
		implemented to prevent					
	her falls.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155567		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	li i	e survey pleted /2011	
	PROVIDER OR SUPPLIER	I HAND REHABILITATION CENTE	STREET 1400 N	ADDRESS, CITY, STATE, ZIP C MEDICAL PARK DRIVE WAYNE, IN46825	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	orientation tour, Director of Nurs. #C had multiple a.m., Resident #C her wheelchair, i an alarm attached On 7/18/11 at 1:3 resting in bed wi her clothing. The position. The clinical reco reviewed on 7/18 indicated the resi the facility on 2/3 which included be left hip arthropla dementia. The MDS (Minin assessment, date- resident required transfer and toile The most current	th an alarm attached to bed was in a low and of Resident #C was 3/11 at 3:20 p.m., and dent was re-admitted to 20/11 with diagnoses but were not limited to, sty and Alzheimer's and Alzheimer's at all risk assessment, icated the resident was at				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUILI		NSTRUCTION 00	COMPL	ETED	
		10000/	B. WING			07/19/2	UII
	PROVIDER OR SUPPLIER SITY PARK HEALTH	AND REHABILITATION CENT	ER	1400 ME	DDRESS, CITY, STATE, ZIP CODE EDICAL PARK DRIVE /AYNE, IN46825		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILED TO THE APPROPRIED TO T		ATE	(X5) COMPLETION DATE
	The resident had 6/11/11, 6/25/11, follows: On 6/11/11 at 9:3 investigation rep was found on the between the whe The report indicated found to have a pher lower back in CM. Neuro check hours The post-fall and indicated the intention of the 6/11/11 fall, in a pull tab alarm wassist to comforts wheelchair, attempt to identificant address, increase frequence and provide visual chebasis.	four recent falls on 7/4/11 and 7/14/11, as 80 a.m., a fall ort indicated Resident #C activity room floor elchair and the couch. Ited Resident #C was burple discoloration on heasuring 5 CM by 0.2 ks were initiated for 72 the fall risk care plan erventions initiated, after included; when up in wheelchair, able position in fly reasons for restlessness by of activity program, heacks on a scheduled					
	sustained a secon condition report was found on the between the whe alarm was sound	205 p.m., Resident #C and fall. A change of indicated Resident #C living room floor elchair and couch, the ing, the resident was					
	· ·	neuro checks were nty two hours and a 3 cm					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567		LDING	NSTRUCTION 00	(X3) DATE : COMPL 07/19/2	ETED	
	PROVIDER OR SUPPLIER	HAND REHABILITATION CENTE	STREET A	EDICAL PARK DRIVE VAYNE, IN46825		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	right knee. The intervention and the post fall 6/25/11 fall, indievaluate wheelch	s initiated on the fall risk care plan, after the cated hospice was to nair positioning, and was bed with floor mat.				
	sustained a third condition report sounding and Re the floor, after sl transfer from the seat in the activi The care plan in	tervention, following the cated the resident was to				
	sustained a fourt condition report was found on the and the door. Th alarm did not so thrown the alarm report noted no p The intervention care plan, follow	s added to the fall risk ring the 7/14/11 fall, rm was put back in place.				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER				NSTRUCTION 00	(X3) DATE S		
		155567	A. BUI B. WIN	LDING IG		07/19/2	011
NAME OF P	PROVIDER OR SUPPLIER		•	1	ADDRESS, CITY, STATE, ZIP CODE EDICAL PARK DRIVE		
UNIVERS	SITY PARK HEALTH	I AND REHABILITATION CENTE	:R	1	VAYNE, IN46825		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		he alarm, the response to					
		positioning of the alarm					
	had been reviewe	dditional supervision of					
	the resident was	_					
	The policy for Fa	ılls Management, dated					
	October 2010, pr	· ,					
	· •	as reviewed on 7/19/11					
	at 1:30 p.m. and						
		Il prevention care plan					
		e with strategies to					
	minimize falls an	ew, revise, and evaluate					
		reness at minimizing falls					
	and injuries	chess at minimizing rans					
		l or suspected causal					
	factors for oppor	tunities to prevent					
	recurrences"						
		led a page of clinical					
	options and strate of fall risks.	egies for the management					
	of fall fisks.						
	This Federal tag	relates to Complaint					
	Number IN00092	2713.					
	3.1-35(d)(2)(B)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155567	B. WIN			07/19/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1400 M	EDICAL PARK DRIVE		
	SITY PARK HEALTH	AND REHABILITATION CENTER			WAYNE, IN46825		(X5)
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION) ded or arranged by the		TAG	DEFICIENCY)		DATE
F0282 SS=D		ovided by qualified persons					
33-D		n each resident's written					
	plan of care.						
	Based on observa	ation, interviews and	F0	282	It is the facility's policy that ser		08/17/2011
	record review, th	e facility failed to			provided or arranged by the fact	ility	
	implement care p	plans to prevent falls.			must be provided by qualified persons in accordance with each		
	This deficiency a	affected 1 of 3 residents			resident's written plan of care.	1	
	with multiple fall	ls in a sample of 3.			Resident C falls careplan was		
	(Resident #C)	•			reviewed on 7/29/11 by IDT to		
	,				ensure appropriate and progress		
	Findings include	<u>.</u>			interventions have been put in p	lace	
					to minimize falls. Other residents with multiple fa	11	
	1 On 7/18/11 a	at 9:30 a.m., during the			previous 3 months shall be revious		
		the ADON (Assistant			by IDT to ensure appropriate	, , , ca	
		ing) indicated Resident			progressive interventions have b	been	
		falls. On 7/18/11 at 10:00			put in place to minimize falls.		
	•	C was observed sitting in			Licensed Nursing staff and IDT	to be	
	•	n the therapy room, with			reeducated on facility's fall management program policy an	đ	
	an alarm attached				procedure. DON or designee w		
		30 p.m., she was observed			review all falls and intervention		
		th an alarm attached to			ensure that the most appropriate		
	_	bed was in a low			measures have been put in place		
	position.	e ded was iii a low			minimize the risk of falls for the	•	
	position.				resident. QA&A will monitor residents w	rith	
	The alimination	nd of Dooi doubt #C			multiple falls monthly to ensure		
		rd of Resident #C was			effectiveness of the staff utilizat		
		3/11 at 3:20 p.m., , and			of the falls management program		
		dent was re-admitted to			a period of 6 months or until pa		
		20/11 with diagnoses			of consistent compliance achiev with a subsequent plan develope		
		out were not limited to,			and implemented as indicated.	Ju	
		sty and Alzheimer's			a impremented as marcated.		
	dementia.						
	The MDS (Minir	num Data Set)					

000459

 155567			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL 07/19/2	ETED	
		155507	B. WIN		DDDDGG GYMY GWYN GYDG	07/19/2	011
NAME OF I	PROVIDER OR SUPPLIE	₹			DDRESS, CITY, STATE, ZIP CODE EDICAL PARK DRIVE		
UNIVER	SITY PARK HEALTI	H AND REHABILITATION CENTI	ER	1	VAYNE, IN46825		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		d 4/21/11, indicated the		IAG	Dia lettike 1		DATE
	· ·	l extensive assistance for					
	transfer and toile						
	transfer and tone	oting .					
	The most curren	t fall risk assessment,					
		licated the resident was at					
	high risk for fall						
	_						
	The resident had	four recent falls on					
	6/11/11, 6/25/11	, 7/4/11 and 7/14/11, as					
	follows:						
	On 6/11/11 at 9:						
		ort indicated Resident #C					
		e activity room floor					
		elchair and the couch.					
	1 ^	ated Resident #C was					
		purple discoloration on					
		neasuring 5 CM by 0.2					
		ks were initiated for 72					
	hours	d the fell midt come mlan					
	1 ^	If the fall risk care plan erventions initiated, after					
	the 6/11/11 fall,	·					
	· ·	when up in wheelchair,					
	assist to comfort	•					
	wheelchair,	word position in					
		fy reasons for restlessness					
	and address,	-					
	increase frequen	cy of activity program,					
	and						
	provide visual cl	necks on a scheduled					
	basis.						
	After the neuro	checks were completed,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	ETED
		155567	B. WIN			07/19/20	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1400 M	EDICAL PARK DRIVE		
	SITY PARK HEALTH	AND REHABILITATION CENTER	₹		VAYNE, IN46825		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re	COMPLETION DATE
IAG		umentation visual checks	+	IAU		+	DATE
		vere provided on a					
	scheduled basis.						
	On 7/19/11 at 12	:10 p.m., the					
		as interviewed. The					
		dicated, after the neuro					
		find no documentation					
		re done on a scheduled					
	basis.						
	On 6/25/11 at 12	:05 p.m., Resident #C					
		nd fall. A change of					
		indicated Resident #C					
	•	living room floor					
		elchair and couch, the					
		ing, the resident was					
		neuro checks were					
	•	nty two hours and a 3 cm					
		ation was noted on her					
	right knee.						
	•	s initiated on the fall risk					
		care plan, after the					
	•	cated hospice was to					
	· ·	nair positioning, and was					
		bed with floor mat.					
	F-2						
	On 7/4/11 at 8:45	5 a.m. Resident #C					
	sustained a third	fall. A change of					
	condition report	indicated the alarm was					
	sounding and Re	sident #C was found on					
	the floor, after sh	e attempted a self					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 07/19/2	LETED		
	PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DRIVE FORT WAYNE, IN46825					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	transfer from the seat in the activit The care plan int 7/4/11 fall, indic be referred to the	wheelchair to the love y room. ervention, following the tated the resident was to						
	sustained a fourth condition report was found on the and the door. The alarm did not sou thrown the alarm report noted no part interventions care plan, follow	in fall. A change of indicated Resident #C is floor between the bed is report indicated the land and the resident had across the room. The						
	was interviewed. #C fell out of bed was not as low as the time of the fa indicated the bed	O0 a.m., the Administrator He indicated Resident d on 7/14/11 and the bed it should have been at ll. The Administrator cord or plug had to be ed could be adjusted to on.						
	October 2010, pr Administrator, w at 1:30 p.m. and "2. Initiate a fa	as reviewed on 7/19/11						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: V1SZ11

Facility ID:

000459

If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/19/2011
		100001	B. WING	ADDRESS, CITY, STATE, ZIP CODE	0771072011
NAME OF P	ROVIDER OR SUPPLIER			MEDICAL PARK DRIVE	
UNIVERS	SITY PARK HEALTH	AND REHABILITATION CENTER	R FORT	WAYNE, IN46825	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
F0323 SS=D	minimize falls and 3. Regularly revicare plan effective and injuries 7. Evaluate actual factors for opport recurrences" The policy include options and strate of fall risks. This Federal tag Number IN00092 3.1-35(g)(2) The facility must environment remain hazards as is possive receives adequated devices to prevent Based on observative record review, the provide increased approaches failed deficiency affects multiple falls in a #B, and #C) Findings include The closed clinic was reviewed or	ew, revise, and evaluate reness at minimizing falls. It or suspected causal tunities to prevent ded a page of clinical regies for the management relates to Complaint 2713. Insure that the resident resident resident resident resident resident resident resident resident residents. The resident residents residents residents residents. The resident residents residents residents residents residents residents residents. The resident residents residents residents residents residents residents residents residents. The residents	F0323	It is the policy of the facility to the resident environment as free accident hazards as is possible a that each resident receives adeq supervision and assistive device prevent accidents. Resident B was discharged from facility on 6/21/11, unable to address. Resident C falls carepi was reviewed on 7/29/11 by ID' ensure appropriate and progress interventions have been put in p to minimize falls. Other residents with multiple fa previous 3 months shall be revieby IDT to ensure appropriate	keep 08/17/2011 of and uate es to a lan T to sive place ulls in
	facility from the	hospital on 5/16/11, with		by 1151 to ensure appropriate	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: V1SZ11 Facility ID:

000459

If continuation sheet

Page 17 of 26

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI	LETED	
		155567	B. WIN			07/19/2	011
	PROVIDER OR SUPPLIER	HAND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DRIVE FORT WAYNE, IN46825				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	limited to, dement Vascular Accider discharged to an 6/21/11. The fall risk assess indicated Reside falls. The fall risk care indicated Reside factors, including weakness and his prevention intervention interven	within reach of call light e of spills and clutter steady gait and balance needs safety cues belongings within reach devices within easy reach and) clear eye wear al therapy evaluation) ated ational therapy			progressive interventions have put in place to minimize falls. Licensed Nursing staff and ID reeducated on facility's fall management program policy a procedure including selection appropriate safety measures to the needs of the resident and updating the plan of care as necessary. DON or designee review all falls and interventicensure that the most appropria measures have been put in pla minimize the risk of falls for tresident. QA&A will monitor residents multiple falls monthly to ensu effectiveness of the staff utiliz of the falls management progra period of 6 months or until pof consistent compliance achievith a subsequent plan develoand implemented as indicated.	T to be Ind of meet will ms to te ce to he with re the ation am for attern eved ped	

Facility ID:

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUILI		nstruction 00	(X3) DATE COMPI 07/19/2	LETED		
		155507	B. WING			07/19/2	2011	
	PROVIDER OR SUPPLIER SITY PARK HEALTH	HAND REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DRIVE FORT WAYNE, IN46825					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
	Pressure sensor (wheelchair) Low bed	pad in bed (and) w/c						
	5/17/11 respective #B was to have a Alarm) on the beand was to receive	, dated 5/16/11 and vely, indicated Resident a PSA (Pressure Sensor ed/ wheelchair at all times we Physical/Occupational es per week for eight						
	dated 5/23/11, in Resident #B requ for transfer and t The BIMS (Bries Status) scores on	uired extensive assistance oileting. f Interview of Mental the MDS assessments, (26/11, and 6/7/11, and #B had severe						
	falls on 5/19/11, follows: On 5/19/11 at 5:: investigation for fell from her who report, a CNA he Sensor Alarm) so resident on the fl wheelchair. The Resident "w	ained three unwitnessed 5/20/11 and 6/4/11; as 50 p.m., A fall m indicated resident #B eelchair. According to the eard the PSA (Pressure bunding and found the oor sitting in front of her as educated 0 (not) to get objects out of reach, to						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	ILDING	NSTRUCTION 00	CO	MTE SURVEY MPLETED 9/2011	
		155567	B. WIN		DDDDGG GWY GTATE GID GOD		9/2011
NAME OF I	PROVIDER OR SUPPLIER			1	.DDRESS, CITY, STATE, ZIP COD EDICAL PARK DRIVE	E	
UNIVER	SITY PARK HEALTH	HAND REHABILITATION CENTE	ΞR	1	VAYNE, IN46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE
IAO		ask for assistance" The	+	IAG			DAIE
	~	Resident #B complained					
		an x-ray of the right hip					
		neuro checks were					
	initiated.						
	On 5/20/11 at 8:0	00 a.m., Resident #B					
	sustained a secor	*					
	~	dition report, dated					
	· ·	d Resident #B was					
		on the bathroom floor,					
		en removed, and the mpted to self transfer to					
		ost-fall care plan indicated					
	"encouraged use	•					
	assistance."	•					
	CNA #1, who dis	scovered the resident on					
	l '	erviewed on 7/19/11 at					
	1	indicated the resident's					
		unding, when she esident on the bathroom					
		ted the resident had shut					
	off her alarm.	ted the resident had shut					
	1 ^ ^	ay report, dated 5/20/11,					
	I -	rity and bony fragment at					
	the greater trocha						
	_	ate 5/21/11 at 7:50 a.m.,					
		an orders were obtained sident to the emergency					
		ion of the right hip.					
		ergency report, date					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155567	B. WIN		-	07/19/2011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		\dashv
NAME OF P	PROVIDER OR SUPPLIER			1	EDICAL PARK DRIVE		
UNIVERS	SITY PARK HEALTH	HAND REHABILITATION CENTE	:R	1	VAYNE, IN46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	П
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE	4
	5/21/11 at 1:12 p	.m., indicated Resident					
	#B was returned	to the facility following					
	an examination a	and a normal MRI					
	(Magnetic Reson	nance Imaging) of the					
	right hip.	.					
	On 6/5/11 at 3·3	0 p.m., Resident #B					
	sustained a third	-					
	_	ation report indicated the					
		ing and Resident #B was					
		or next to her bed.					
	According to the	report, she had					
	attempted to tran	sfer from the wheelchair					
	to the bed withou	at assistance and missed					
	the bed. The repo	ort indicated the "resident					
	-	on use of call light." The					
		and non-skid socks,					
		planned, were continued.					
	previously eare p	raimed, were continued.					
	The care plan inc	dicated the only new fall					
	•	rention attempted for the					
	•	ired resident, following					
		, ,					
	the falls, was re-						
	_	o use the call light. There					
		tation the use of the PSA					
		ved or that the need for					
	additional superv	vision was considered or					
	planned.						
	07/10/1112	.10					
	On 7/19/11 at 12	•					
	administrator was interviewed regarding						
	Resident #B's fal						
	re-education of a	dementia resident was					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP - 07/19/2	LETED			
	PROVIDER OR SUPPLIER	H AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DRIVE FORT WAYNE, IN46825					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	indicated more "	te intervention. He tangible" interventions implemented to prevent						
	orientation tour, Director of Nurs #C had multiple a.m., Resident #6 her wheelchair, i an alarm attache On 7/18/11 at 1: resting in bed wi her clothing. The position. The clinical reco reviewed on 7/18 indicated the res the facility on 2/ which included to left hip arthropla dementia. The MDS (Minin assessment, date	and p.m., she was observed than alarm attached to be bed was in a low and of Resident #C was a street was re-admitted to 20/11 with diagnoses out were not limited to, sty and Alzheimer's and mum Data Set described 4/21/11, indicated the dextensive assistance for						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155567	B. WIN			07/19/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
		LAND DELIABILITATION CENTE	·D	1	EDICAL PARK DRIVE		
		I AND REHABILITATION CENTE	:K	FORT	VAYNE, IN46825		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAG		fall risk assessment,	+	IAG			DATE
		*					
	dated 7/8/11, indicated the resident was at high risk for falls.						
	lingii risk for fairs	5.					
	The resident had	four recent falls on					
		7/4/11 and 7/14/11, as					
	follows:	// -/ 11 and // 1 -/ 11, as					
	On 6/11/11 at 9:3	30 am afall					
		ort indicated Resident #C					
		e activity room floor					
		elchair and the couch.					
		ated Resident #C was					
	•	ourple discoloration on					
	^	neasuring 5 CM by 0.2					
		ks were initiated for 72					
	hours	,					
		the fall risk care plan					
	-	erventions initiated, after					
	the 6/11/11 fall, i	· · · · · · · · · · · · · · · · · · ·					
	-	when up in wheelchair,					
	assist to comforta	_					
	wheelchair,	-					
	attempt to identif	fy reasons for restlessness					
	and address,						
	increase frequenc	cy of activity program,					
	and	-					
	provide visual ch	necks on a scheduled					
	basis.						
	After the neuro c	hecks were completed,					
	there was no doc	umentation visual checks					
	of Resident #C w	vere provided on a					
	scheduled basis.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155567	B. WIN			07/19/2	011
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	PROVIDER OR SUPPLIER			1400 M	EDICAL PARK DRIVE		
	SITY PARK HEALTH	AND REHABILITATION CENTE	R	FORT V	VAYNE, IN46825		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
	On 7/19/11 at 12						
		as interviewed. The					
		dicated, after the neuro					
		find no documentation					
	visual checks we	re done on a scheduled					
	basis.						
	On 6/25/11 at 12	:05 p.m., Resident #C					
	sustained a secon	nd fall. A change of					
	condition report	indicated Resident #C					
	-	e living room floor					
		elchair and couch, the					
		ing, the resident was					
		neuro checks were					
	-	nty two hours and a 3 cm					
		ation was noted on her					
	right knee.	ation was noted on her					
	•	s initiated on the fall risk					
	-	care plan, after the					
		cated hospice was to					
		nair positioning, and was					
	to provide a low	bed with floor mat.					
		5 a.m. Resident #C					
		fall. A change of					
	condition report	indicated the alarm was					
	sounding and Re	sident #C was found on					
	the floor, after sh	e attempted a self					
	transfer from the	wheelchair to the love					
	seat in the activit	y room.					
		ervention, following the					
	-	eated the resident was to					
	,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	155567	A. BUI	LDING	00	07/19/2	
		133307	B. WIN		PPPPG GWY GWAR GIR GODE	01/13/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE EDICAL PARK DRIVE		
UNIVERS	SITY PARK HEALTH	HAND REHABILITATION CENTE	ΞR	1	VAYNE, IN46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	_	ID	·		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
ı	be referred to the	erapy.	Ī				
		55 a.m. Resident #C					
		h fall. A change of					
	•	indicated Resident #C					
		floor between the bed					
		e report indicated the					
		and and the resident had					
		across the room. The					
	report noted no p	2					
		s added to the fall risk					
	_	ing the 7/14/11 fall,					
	indicated the alar	m was put back in place.					
	There was no doo	cumentation the					
		the alarm, the response to					
		positioning of the alarm					
	had been reviewe						
		dditional supervision of					
	the resident was	•					
		•					
	On 7/19/11 at 9:0	00 a.m., the Administrator					
	was interviewed.	He indicated Resident					
	#C fell out of bed	d on 7/14/11 and the bed					
	was not as low as	s it should have been at					
	the time of the fa	ll. The Administrator					
	indicated the bed	cord or plug had to be					
	-	ed could be adjusted to					
	the lowest position	on.					
	TT 1: 0 =	11 34					
		alls Management, dated					
	October 2010, pr	-					
	Administrator, w	as reviewed on 7/19/11					

000459

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/19/2011		
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DRIVE FORT WAYNE, IN46825			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION DATE
	when appropriate minimize falls at 3. Regularly revicare plan effective and injuries 7. Evaluate actual factors for opport recurrences" The policy including options and strate of fall risks.	Il prevention care plan e with strategies to nd injuries. ew, revise, and evaluate veness at minimizing falls al or suspected causal tunities to prevent ded a page of clinical egies for the management relates to Complaint				